Scott Walker
Governor

Jon Litscher
Secretary

Mailing Address

Wisconsin Secure Program Facility
Health Services Unit
P O. Box 1000
Boscobel, WI 53805

State of Wisconsin
Department of Corrections

CERTIFICATION OF RECORDS

I, Jolinda Waterman (First Name, Last Name) Record Custodian/designee for Wisconsin Secure Program Facility (Facility/Office)

do hereby certify that I have compared the attached copies of the documents pertaining to

Conner, Eric (First Name, Last Name of Offender or Employee) #420475 [redacted] (x☐ DOC Number (offender records) OR ☐ Date of Birth (employee records))

that are in the custody of the Wisconsin Department of Corrections and to the best of my knowledge, the

254 (Number) pages being provided comprise true and correct copies of those documents requested.

CHECK ONE OF THE BOXES BELOW

☐ Copy of the Original Request Attached
or
x☐ Documents Described Below

Jolinda Waterman
Record Custodian/Designee

1-24-18
Date Signed

NOTE This form does not need to be notarized

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3496 (1/2009)

WISCONSIN

PSYCHIATRIC REPORT - TRANSFER OF CARE

PATIENT NAME (Last, First)	DATE OF APPOINTMENT	FACILITY (via TELEPSYCHIATRY)
CONNER, ERIC	02/10/2017	Wisconsin Secure Program Facility
PSYCHIATRIST NAME (Last, First)	DOC NUMBER	DATE OF BIRTH
Strelnick, Karl	420475	[redacted]

NARRATIVE:
The patient transfers from WCI carrying a diagnosis of posttraumatic stress disorder with nightmare disorder and alcohol use disorder. He is on trazodone for sleep, prazosinto prevent nightmares and Mouth Kote Dry Mouth Spray He wants to continue the trazodone because it is helpful, and he says the Mouth Kote Dry Mouth Spray is effective. He wants prazosin stopped and in fact he stopped taking a week or two ago. His reasoning for stopping it is that it interferes with his communication with John who was his homicide victim. He says that he takes both trazodone and prazosin and he sleeps too deeply to be in communication with John. The story is given in a dramatic fashion and there is no psychotic tone. It is more child like I agreed to stop prazosin.

CURRENT MEDICATIONS:
1. Trazodone 200 milligrams at bedtime as needed for sleep.
2. Prazosin 15 milligrams at bedtime.
3 Mouth Kote Dry Mouth Spray as needed.
4. Ibuprofen 800 milligrams two times a day

MENTAL STATUS EXAMINATION:
The patient presents as a 29-year-old African-American male in typical prison dress with adequate hygiene and grooming. He is calm and cooperative. There are no unusual movements and no psychomotor changes Speech is normal rate, normal tone, and normal volume without pressure Affect is mildly labile. Mood is mildly anxious. Thought processes are goal directed and logical He denies suicidal or homicidal ideation. There are no hallucinations or delusions. He says that he has been in communication with his murder victim John who wants him off of prazosin which interferes with their communication. He continues to have nightmares at the decreased rate of three to four times a week despite stopping prazosin He is alert and oriented to time, place, and person. His short-term and long-term memory is intact His insight is fair His judgment is fair.

IMPRESSION:
The patient says that the mouth spray and trazodone are effective and wants to continue them. He says prazosin decreased nightmares a little but he thinks it interferes with his communicating with the murder victim, John, so wants it stopped. According to the patient, he stopped the medication one or two weeks ago. There has been no change in nightmares since this stop

DIAGNOSES:
1 Posttraumatic stress disorder with nightmare disorder.
2. Rule out personality disorder, unspecified.
3. Alcohol use disorder, in a controlled environment

TREATMENT PLAN:
1. Continue trazodone 200 milligrams at bedtime as needed for sleep
2. Stop prazosin.
3. Continue Mouth Kote Dry Mouth Spray as needed.

FOLLOW-UP INTERVAL (APPOINTMENT):
Return to clinic in eight weeks.

INITIALS OF TRANSCRIBER DSK DATE DICTATED 02/10/2017 DATE TRANSCRIBED 02/11/2017

DISTRIBUTION: Original-Medical Chart, Psychiatric Services Section, Copy-PSU record, Psychiatric Report Section

PATIENT NAME (Last, First)	DATE OF APPOINTMENT	FACILITY (via TELEPSYCHIATRY)
CONNER, ERIC	02/10/2017	Wisconsin Secure Program Facility
PSYCHIATRIST NAME (Last, First)	DOC NUMBER	DATE OF BIRTH
Strelnick, Karl	420475	[redacted]

++ THIS DOCUMENT IS A DRAFT UNLESS AN ELECTRONIC SIGNATURE IS PRESENT BELOW ++

Electronically signed by: Strelnick, Karl M.D. on 02/15/2017 20 57.10

DISTRIBUTION: Original-Medical Chart, Psychiatric Services Section, Copy-PSU record, Psychiatric Report Section

EXHIBIT 1000 - 3

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3388 (Rev 7/2014)

WISCONSIN

HEALTH & PSYCHOLOGICAL ROUNDS IN SEGREGATION

NAME (LAST, FIRST or use label).	DOB:	DOC #:	FACILITY.
Conner Eric		420475	WSPF

Date HSU Notified of Segregation Placement. Medical Chart Reviewed by: Date:

☐ No contraindications ☐ Medical contraindications (If checked, see Progress Note)

Check box to indicate type of round ☒ MEDICAL ROUND ☐ PSYCHOLOGICAL ROUND

Date of Round	Time of Round	Responsive (Explain "No" in Comments)		Complaints (Explain "Yes" in Comments)		Signs of Injury /Illness (Explain "Yes" in Comments)		Mental Health Concerns (Explain "Yes" in comments)		Comments – when indicated in columns to the left (Record in Progress Notes if More Room is Needed)	Staff Name & Credentials
		Yes	No	Yes	No	Yes	No	Yes	No		
1-29-17	MPOL	☒	☐	☐	☒	☐	☒	☐	☒	movement noted	RF RN
2-5-17	1800	☒	☐	☐	☒	☐	☒	☐	☒	Advised submit HSR questions about x-ray results	BL, RN
2.13.17	0830	☒	☐	☐	☒	☐	☒	☐	☒	Talked at cell front	G. Lee, RN
2-14-17	0520	☒	☐	☐	☒	☐	☒	☐	☒	Laying on floor, movement noted	BE, RN
2-14-17	2030	☒	☐	☐	☒	☐	☒	☐	☒	stood at C.F. - masturbating and asked for "cream for feet"	BL, RN
2-15-17	0515	☒	☐	☐	☒	☐	☒	☐	☒	Laying on floor, movement noted	BE, RN
2.13.17	1615	☒	☐	☐	☒	☐	☒	☐	☒	Talking At Cell Front	GL, RN
2.16.17		☒	☐	☐	☒	☐	☒	☐	☒	Talking At cell Front	GL, RN
2-17-17	0520	☒	☐	☐	☒	☐	☒	☐	☒	Laying on floor, Movement noted	BE, RN

DISTRIBUTION: Original – For Medical Rounds Medical Chart, Flow Sheet Section. For Psychological Rounds: PSU Record, Referrals/Screening/Contacts Section

EXHIBIT 1000 - 4

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3388 (Rev 7/2014)

WISCONSIN

HEALTH & PSYCHOLOGICAL ROUNDS IN SEGREGATION

NAME (LAST, FIRST or use label)	DOB	DOC #	FACILITY: WSPF
Conner Eric		420475	

Date HSU Notified of Segregation Placement. Medical Chart Reviewed by Date

☐ No contraindications ☐ Medical contraindications (If checked, see Progress Note)

Check box to indicate type of round ☒ MEDICAL ROUND ☐ PSYCHOLOGICAL ROUND

Date of Round	Time of Round	Responsive (Explain "No" in Comments)		Complaints (Explain "Yes" in Comments)		Signs of Injury /Illness. (Explain "Yes" in Comments)		Mental Health Concerns (Explain "Yes" in comments)		Comments – when indicated in columns to the left (Record in Progress Notes if More Room is Needed)	Staff Name & Credentials
		Yes	No	Yes	No	Yes	No	Yes	No		
2-17-17	1630	☒	☐	☒	☐	☐	☒	☐	☒	noted rubbing lotion mucinex cream on camera	RF-RN
2-18-17	0515	☒	☐	☐	☒	☐	☒	☐	☒	Laying on floor, movement noted	BE, RN
2-19-17	0500	☒	☐	☐	☒	☐	☒	☐	☒	Laying on floor, Movement noted	BE, RN
2-18-17 (Late entry)	2030	☒	☐	☐	☒	☐	☒	☐	☒		GL, RN
4-2-17 (Duplicate)	0525	☒	☐	☐	☒	☐	☒	☐	☒	Laying on floor, movement noted —	BE, RN
~~2030~~ 4-2-17	2030	☒	☐	☐	☒	☐	☒	☐	☒	TOOK HS meds	GL, RN
4-3-17	0455	☒	☐	☐	☒	☐	☒	☐	☒	Laying on floor, movement noted —	BE, RN
4-5-17	0547	☒	☐	☐	☒	☐	☒	☐	☒	At CF took meds	MF RN
4-6-17	0530	☒	☐	☐	☒	☐	☒	☐	☒	Laying on floor, Movement noted	BE, RN

DISTRIBUTION: Original – For Medical Rounds: Medical Chart, Flow Sheet Section For Psychological Rounds: PSU Record, Referrals/Screening/Contacts Section

EXHIBIT 1000 - 5

EPARTMENT OF CO[illegible]ECTIONS
ivision of Adult Institutions
OC-3388 (Rev 9/2016)

WISCON[illegible]

HEALTH & PSYCHOLOGICAL ROUNDS IN RESTRICTIVE HOUSING

NAME (LAST, FIRST or use label)	DOB:	DOC #	FACILITY.
Conner, Eric		420475	WSPF

Date HSU Notified of Restrictive Housing Placement | Medical Chart Reviewed by | Date

☐ No contraindications ☐ Medical contraindications (If checked, see Progress Note)

Check box to indicate type of round ☐ MEDICAL ROUND ☐ PSYCHOLOGICAL ROUND

Date of Round	Time of Round	Responsive (Explain "No" in Comments)		Complaints (Explain "Yes" in Comments)		Signs of Injury /Illness (Explain "Yes" in Comments)		Mental Health Concerns (Explain "Yes" in comments)		Comments – when indicated in columns to the left (Record in Progress Notes if More Room is Needed)	Staff Name & Credentials
		Yes	No	Yes	No	Yes	No	Yes	No		
2/24/17	1145	X			X		X		X	States "OK" Standing @ cell front	QWRN
2-24-17	1850									Talks to RN @ C.F. Wondering about lotions in obs.	BSK, RN
2-25-17	0715									Talked @ CF, took AM meds	
2-25-17	1615									Talks to RN @ C.F. No complaints	BSK, RN
2-26-17	1480									mouth noted	NFL
2-27-17	0525									Laying on floor, movement noted	BE, RN
2-27-17	1945									meds @ cell front, ∅ complaints	MK RN
2-28-17	2215									Standing @ C.F.	BSK, RN
3-1-17	2020									Standing @ cell Front	Electronic

EXHIBIT 1000 - 6

STRIBUTION: Original – For Medical Rounds Medical Chart, Flow Sheet Section For Psychological Rounds. PSU Record, Referrals/Screening/Contacts Section

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3021 (Rev. 8/2007)

WISCONSIN

PROGRESS NOTES

CONNER, Eric
#420475 [redacted]

DOC NUMBER

DATE	TIME	PROGRESS NOTES – SUBJECT, OBJECTIVE, ASSESSMENT, PLAN
		DATE 2-22-17 REFUSED scheduled lab draw today. DOC 3220 Refusal of Recommended treatment sent or presented to patient for signature. BE. MD
2-25-17	1515	RN to unit for Alpha med pass. RN asked per security, Lt. Chidanault to assess Pt. and apply cream to feet if needed in unit HSU. Vitals taken: BP - 148/97, P-74, T-98. No c/o pain. Pt's feet were washed c betasept, rinsed & dried. Miconazole cream applied to both feet. Pt. was then taken back to observation cell. B. Kramer, RN
2-25-17	1515	Pt's feet were red, very dry, but skin was intact. B. Kramer, RN

DISTRIBUTION: Original – Medical Chart, Progress Notes Section

EXHIBIT 1000 - 7

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev. 9/2016)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Adm Code
Ch DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Conner	Eric	420475
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
WSPF	Alpha Unit-415	3-2-17

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT.

I understand the following

- The Department of Corrections shall charge a copayment of $7 50 for a visit (face to face contact) initiated by a patient when a copayment is required
- I will not be denied care if I am unable to pay the copayment
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required

PATIENT SIGNATURE ▶ N/A

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE | DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided. Place all 4 pages of the completed form in the sick call box. The HSU will send a copy back to you indicating that your request has been received

☐ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☒ OTHER: Nurse Practitioner & To HSU Manager.

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

I would like the 2-22-17 blood draw & Stool sample I was on observation Status.

DATE RECEIVED: TO BE STAMPED BY HSU

MAR 0 3 2017

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed.

☐ Nursing Sick Call ☐ Today ☐ Date (if not today)

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other.

☐ Refer HSR to ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other.

☐ Refer for copies only ☐ Refer for Health Care Record review appointment.

☐ Educational material attached (Specify) ☐ Other.

COMMENT / INFORMATION

We will reschedule it. If you can have creams, will dispense off cart.

PRINT STAFF NAME: Weller RN

DATE OF HSU RESPONSE: 3/3/17

ORIGINAL - PATIENT REQUEST FOLDER

EXHIBIT 1000 - 8

MAR 0 3 2017

3-2-17

From: Eric Conner #420475
TO: HSU Manager.

Dear HSU Manager:

I was told by nurse Woods on 2-1-17, Per You, that I Could not receive my Foot Cream or Skin lotion while I was on observation Status. My feet gets really dry skin Cracks and hurts. If I'm not given these Creams. Regarless of my Status, to not given me these medical Creams for a medical problem is deliberate Indifference; a violation of my prisoner rights.

I Just Came out of observation after being on it Since 2-13-17. I will be going back on on 3-3-17. I would like for you to give the ok to all nurses Just like Capt. Eser was, to allow me to receive these Creams.

O.C.

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3639 (Rev 7/2013)

WISCONSIN

NURSING ENCOUNTER PROTOCOLS

(see DOC3639A for completion guidelines)

PATIENT NAME (Last, First)	DOC NUMBER	DATE	TIME
Conner, Eric	420475	3.5.17	1715

ENCOUNTER INITIATED BY: ☐ HSR/DSR/PSR Date ☒ Patient Verbal Request ☐ Staff Request Other (List)

History Information Received From: ☒ Patient ☐ Patient unable to provide any information ☐ Staff

☐ HSU staff responded to scene ☒ Patient presented to HSU ☒ Ambulatory ☐ W/C ☐ Cart ☐ Other (list)

PERTINENT PAST MEDICAL HISTORY

CHIEF COMPLAINT: Pain In Rectum & defecating

SUBJECTIVE

"Blood In Stool ... Pain & sitting and Pain & defecating"

OBJECTIVE

A&A x 3, No Acute S/S of Distress

ALLERGIES ☐ Medication Profile Reviewed ☐ Tetanus Up to Date (If Applicable)

VITAL SIGNS/SYSTEMS ASSESSMENT (Record assessment data and check all that apply and write any additional notes on 2nd page)

Temperature ☐ Oral ☐ Axillary ☐ Rectal ☐ Tympanic 70 Pulse ☒ Radial ☐ Apical ☐ Regular ☐ Irregular

Respirations 16 SpO2 99 ☒ RA ☐ O2@ L/PM PEAK FLOWS: BLOOD GLUCOSE:

Laying B/P P Sitting B/P 114/80 P Standing B/P P WT 200 ☒ LOSS ☐ GAIN 14# MONTHS 6

PAIN PAIN LOCATION. Rectum ONSET:

DESCRIPTION Reports Pain Sitting In Rectum INTENSITY (0-10): 9 /10 WORST PAIN RATING: /10

TOLERABLE LEVEL: /10 PAIN RELIEF INTERVENTIONS

PSYCHOLOGICAL

☒ Assessed with No Apparent Abnormalities ☐ Not Assessed

☐ Disoriented ☐ Hallucinations ☐ Delusions

☐ Disheveled ☐ Flat ☐ Anxious ☐ Depressed ☐ Insomnia

☐ Argumentative ☐ Angry ☐ Tearful ☐ Suicidal Ideations ☐ Self Harm

RESPIRATORY

☒ Assessed with No Apparent Abnormalities ☐ Not Assessed

☐ Asymmetrical ☐ Tachypnea ☐ Bradypnea ☐ Dyspnea

☐ Barrel Chest ☐ Shallow ☐ Orthopnea ☐ Irregular pattern

☐ Cough ☐ Productive Sputum Color:

☐ Use of accessory muscles

RUL	☐ Wheezes	☐ Insp	☐ Exp	☐ Crackles	☐ Diminished
RML	☐ Wheezes	☐ Insp	☐ Exp	☐ Crackles	☐ Diminished
RLL	☐ Wheezes	☐ Insp	☐ Exp	☐ Crackles	☐ Diminished
LUL	☐ Wheezes	☐ Insp	☐ Exp	☐ Crackles	☐ Diminished
LLL	☐ Wheezes	☐ Insp	☐ Exp	☐ Crackles	☐ Diminished

GASTROINTESTINAL

☒ Assessed with No Apparent Abnormalities ☐ Not Assessed

Last BM: ☐ Constipation ☐ Frequent Use of Laxatives

☐ Diarrhea /24 hours ☐ Nausea ☐ Vomiting /24 hours

☐ Chewing Difficulty ☐ Swallowing Difficulty ☐ Anorexia

ABDOMEN ☐ Distention ☐ Rigidity ☐ Rebound Tenderness

RUQ	☐ Hyperactive	☐ Hypoactive	☐ Absent	☐ Tenderness
Q	☐ Hyperactive	☐ Hypoactive	☐ Absent	☐ Tenderness
	☐ Hyperactive	☐ Hypoactive	☐ Absent	☐ Tenderness
LLQ	☐ Hyperactive	☐ Hypoactive	☐ Absent	☐ Tenderness

EENT

☐ Assessed with No Apparent Abnormalities ☒ Not Assessed

EAR ☐ Right ☐ Left ☐ Pain ☐ Redness ☐ Drainage ☐ Cerumen

☐ Decreased/Difficulty Hearing ☐ Dull/Bulging Tympanic Membrane

EYE ☐ Right ☐ Left ☐ Pain ☐ Redness ☐ Drainage

Snellen: Left ____/____ Right ____/____ Both ____/____

THROAT ☐ Red ☐ Exudate ☐ Neck Lymph Node Swelling

ORAL MUCOSA ☐ Dry ☐ Sores ☐ Lesions ☐ Bleeding

NOSE ☐ Nasal Drainage ☐ Nasal Irritation ☐ Sinus Tenderness

Dental Issues Require: Dental Pain/Swelling/Bleeding Encounter, ☐ DOC-3648 Dental Pain/Swelling/Bleeding Questionnaire

CARDIOVASCULAR

☒ Assessed with No Apparent Abnormalities ☐ Not Assessed

☐ Tachycardia ☐ Bradycardia ☐ Irregular ☐ Palpitations ☐ Fatigue

☐ Chest Pain/Angina ☐ Diaphoresis ☐ Numbness ☐ Tingling

Heart Sounds: Cap refill ☐ >3 sec. ☐ < 3 sec

Edema Location: Edema ☐ Pitting: ☐ Non Pitting:

GENITOURINARY- REPRODUCTIVE

☐ Assessed with No Apparent Abnormalities ☒ Not Assessed

☐ Hematuria ☐ Urine Cloudy ☐ Urine Odor ☐ Flank Pain ☐ Dysuria

☐ Hesitancy ☐ Burning ☐ Nocturia ☐ Frequency ☐ Lesions ☐ Discharge

☐ Current/Frequent Diagnosis of UTI ☐ Foley

LMP: ☐ Menopause ☐ Pregnant EDC:

Last Pap Smear Last Mammogram.

☐ Breast Lump ☐ Nipple Discharge ☐ Breast Pain

☐ Testicular Swelling ☐ Penis Lesions

DISTRIBUTION Original – Medical Chart, Progress Notes Section

PATIENT NAME (Last, First)	DOC NUMBER	DATE	TIME
Conner, Eric	420475	3.5.17	1715

NEUROLOGICAL

- [x] Assessed with No Apparent Abnormalities ☐ Not Assessed
- ☐ Seizure Activity minutes
- ☐ Confused ☐ Person ☐ Place ☐ Time
- ☐ Unresponsive ☐ Comatose ☐ Lethargic
- ☐ Aphasia ☐ Garbled Speech ☐ Slurred Speech ☐ Combative
- ☐ Headache ☐ Dizziness ☐ Numbness Location
- ☐ Paralysis Right ☐ Upper ☐ Lower Left ☐ Upper ☐ Lower
- ☐ Weakness Right ☐ Upper ☐ Lower Left ☐ Upper ☐ Lower
- PUPILS ☐ Unequal ☐ Sluggish ☐ Nonreactive ☐ Pinpoint ☐ Dilated

DERMATOLOGICAL

- ☐ Assessed with No Apparent Abnormalities [x] Not Assessed
- PROBLEM LOCATION
- ☐ Poor Turgor ☐ Diaphoretic ☐ Moist ☐ Hot ☐ Flushed ☐ Cool
- ☐ Clammy ☐ Pale ☐ Cyanotic ☐ Mottled ☐ Jaundice ☐ Itching
- ☐ Rash ☐ Redness ☐ Laceration ☐ Abrasion ☐ Macule ☐ Papule
- ☐ Nodule ☐ Vesicle ☐ Bulla ☐ Pustule
- BURN ☐ Partial Thickness ☐ Full Thickness
- ☐ Pressure Ulcer
- Any wounds require a Wound Care Flow Sheet DOC3024A Wound Care Initial Assessment ☐ DOC-3024A Wound Care Initial Assessment

For full neurological assessment and/or ongoing monitoring link to form ☐ DOC-3424F Neurological Assessment Flow Sheet

MUSCULOSKELETAL

- ☐ Assessed with No Apparent Abnormalities [x] Not Assessed
- ☐ CMS Abnormalities ☐ ROM Limitations ☐ Crepitus
- ☐ Shortening ☐ Rotation ☐ Unable to Bear Weight
- Problem Location:
- ☐ Deformity ☐ Swelling/edema ☐ Bruising
- ☐ Muscle Cramps/spasms ☐ Calf Tenderness

Additional Progress Notes: Patient c/o Pain In Rectum & defecating, Blood In stool & Pain & sitting. Chart Review, Patient has Hx. of hemmoroid. Reports Bright Red Blood on Stool & on paper. Patient had seen ACP, In February. Patient refused his Blood work, Patient In observation for suicidal ideations, unable to have hemmocult supplies In obs cell. Patient Questions Colon-Rectal cancer, Reassurance given Sx go along & hemmoroid and given Hx. of hemmoroids. Patient Also had c/o Abd. Pain and Reports Lactaid Is not working & questions Lactose free diet. Requesting to see ACP for ongoing Abd Pain and Rectal Bleeding.

PROTOCOLS UTILIZED/NO APPLICABLE PROTOCOL

NURSING DIAGNOSIS

Acute Pain R/t Rectal Pain

INTERVENTIONS PROVIDED

Nursing Assessment

EDUCATION PROVIDED

Hemmoroid Sx

[x] Expresses Understanding of Instructions Provided

REFERRAL TO ADVANCED CARE PROVIDER

☐ Stat Referral Off-site	☐ Stat Referral On-site	☐ Stat Referral to On-Call	ACP Name:	Date. Time:
☐ Referred to ACP Chart Review Only		Date/Time/Initials of ACP Review		☐ No Referral Necessary
Schedule ACP Face to Face	☐ Within 24 Hours	[x] Within 7 days	☐ Within 14 days	☐ Within 30 days

NURSING FOLLOW-UP

[x] No follow-up necessary ☐ Nursing Follow-up scheduled (list date) [x] Patient advised to submit HSR PRN if no improvement

REGISTERED NURSE SIGNATURE	DATE SIGNED	
G. Lee, RN / [illegible], RN	3.5.17	Copay Charged: ☐ Yes [x] No

DISTRIBUTION Original – Medical Chart, Progress Notes Section

PATIENT NAME Last	First	MI	DOC NUMBER
Conner, Eric			420475

DATE	TIME	PROGRESS NOTES – SUBJECT, OBJECTIVE, ASSESSMENT, PLAN
03/07/17	1430	29 y/o male enters the clinic c/o ongoing epigastric problems S: As above. States that pain in abdomen at diarrhea having unchanged c use of Lactaid. Pt. believes he has an allergy to lactose. O: VS: 112/62 – 78 – 18. Abd: Flat, BSx4. NT/ND. A: Epigastric distress P: D/C Lactaid. Lab: RAST test for cow's milk. ——— [illegible signature]
3/8/17	1300	Pt seen @ CF. Unit staff had reported that Pt had eaten breakfast and would not be able to have fasting lab work. Pt states he did not eat breakfast, he just chewed it up and spit it out. Will schedule labs for next week ——— N. Bethel RN
3-8-17 (Late)	1415	At 0400, RN received phone call from Lt Leffler stating that there is no need for RN on call to come to institution – pt will be removed from full bed restraints. ——— B. Kramer RN
		DATE 3-15-17 Pt seen in HSU on unit for lab draw. Pt was explained risks and benefit of lab ~~GLUP~~ BMP, GLYH, draw. HGB/HCT, LIPDPL Rast - cow milk N. Bethel RN

DISTRIBUTION Original – Medical Chart, Progress Notes Section

EPARTMENT OF CO. CTIONS
vision of Adult Institutions
OC-3388 (Rev 9/2016)

WISCON

HEALTH & PSYCHOLOGICAL ROUNDS IN RESTRICTIVE HOUSING

NAME (LAST, FIRST or use label)	DOB.	DOC #·	FACILITY·
Conner, Eric		420475	WSPF

Date HSU Notified of Restrictive Housing Placement | Medical Chart Reviewed by | Date

☐ No contraindications ☐ Medical contraindications (If checked, see Progress Note)

Check box to indicate type of round ☐ MEDICAL ROUND ☐ PSYCHOLOGICAL ROUND

Date of Round	Time of Round	Responsive (Explain "No" in Comments) Yes	Responsive No	Complaints (Explain "Yes" in Comments) Yes	Complaints No	Signs of Injury /Illness (Explain "Yes" in Comments) Yes	Signs of Injury /Illness No	Mental Health Concerns (Explain "Yes" in comments) Yes	Mental Health Concerns No	Comments – when indicated in columns to the left (Record in Progress Notes if More Room is Needed)	Staff Name & Credentials
1077	2210	☑	☐	☐	☑	☐	☑	☐	☑	Lying on floor by toilet – sat up to speak c C.O. at C.F.	BS, RN
11-17	07:00	☑	☐	☐	☑	☐	☑	☐	☑	sitting on floor, acknowledged RN	NB RN
11-17	2030	☑	☐	☐	☑	☐	☑	☐	☑	standing @ CF, spoke c RN	MC RN
12-17	07:00	☑	☐	☐	☑	☐	☑	☐	☑	Talked to RN	NB RN
12-17	1500	☑	☐	☐	☑	☐	☑	☐	☑	Checked during R.H. Rounds	PE RN
13-17	0546	☒	☐	☐	☒	☐	☒	☐	☒	Laying on floor, movement noted	BE RN
13-17	2030	☒	☐	☐	☒	☐	☒	☐	☒	Standing at cell Front	EC, RN
1517	0500	☒	☐	☐	☒	☐	☒	☐	☒	Laying on floor, Movement noted	BE, RN
16	0715	☑	☐	☐	☑	☐	☑	☐	☑	eating	RT RN

DISTRIBUTION: Original – For Medical Rounds Medical Chart, Flow Sheet Section For Psychological Rounds, PSU Record, Referrals/Screening/Contacts Section

EXHIBIT 1000 - 13

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3021 (Rev 8/2007)

WISCONSIN

PROGRESS NOTES

PATIENT NAME Last	First	DOC NUMBER
Conner, Eric		420475

DATE	TIME	PROGRESS NOTES – SUBJECT, OBJECTIVE, ASSESSMENT, PLAN
3/15/17	08'00	Spoke with Pt. in Alpha HSU for lab work. Pt c/o feet being dried and cracked. Pt. states that PSU does not allow him to have his creams or lotions while in clinical observation. Pt. encouraged to get out of clinical obs, but replies that he is going to stay there "awhile". Unit staff informed this RN that Pt. is no longer allowed to have creams + lotions in clinical obs due to him covering his camera with them. Will notify HSM. – N. Bethel RN
3/15/17	1305	Pt. seen in Alpha HSU. Feet soaked in Epsom salt + warm water for 5 minutes. Feet dried + Mineria cream applied. Pt is calm and cooperative — N. Bethel RN
3-7-17	2108	Late entry
3-16-17	1430	Called to unit for cell entry for placing patient in mechanical restraints. Patient was cooperative and did not verbalize any complaints during or after the process. Patient appeared calm and small area noted (approx. 3 cm x 3cm) of reddened, swollen area to left forehead from patient banging his head purposely on his door. No other injuries noted. CMS + restraint checks completed. Pt. offered fluid & toileting — P Edl, RN

DISTRIBUTION Original – Medical Chart, Progress Notes Section

EXHIBIT 1000 - 14

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3021 (Rev 8/2007)

WISCONSIN

PROGRESS NOTES

PATIENT NAME Last	First	DOC NUMBER
Conner, ~~Eric~~ PE	Eric	420475

DATE	TIME	PROGRESS NOTES – SUBJECT, OBJECTIVE, ASSESSMENT, PLAN
03-16-17	1745	RN attempted to see pt for ~~HSR~~ error ~~rtt~~ foot care daily. pt refused to be seen. pt refused to sign DOC-3220. MK RN
3-17-17	1433	Spoke with pt @ CF. Pt refused foot tx d/t not having shoes to put on and says the cream comes off on the cement floor. Pt informed that HSU doesn't control what is allowed in his cell. Pt informed that once he is out of observation status he won't be restricted on ~~what~~ PE having shoes in his cell. Pt verbalized understanding. S. Edl, RN
3-17-17	2000	During HS Med PASS, Patient do not receive his foot care today. I offered to Patient to do his foot care after med PASS, Patient Refused, Reports to Late Now and getting Ready for Bed, Confirmed once more w Patient that he did not want his foot care. Compliant w med PASS, Denies Any other complaints at this time — [illegible] RN
3-20-17	0755	Team call patient with plastic bag on head did hand it over willingly with staff directive @ assessment — R Fellows
3.20.17	0930	Per Sgt. Wallace, pt. is unable to come out for HSU RN visit of daily foot soak per security reasons. Pt. remains in Clinical observation. — S Anderson

DISTRIBUTION Original – Medical Chart, Progress Notes Section

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3220 (Rev 5/2010)

WISCONSIN
Wisconsin Statute
Section 302 384

REFUSAL OF RECOMMENDED HEALTH CARE

PATIENT NAME (Last, First)	DOC NUMBER	FACILITY
Conner, Eric	420475	WSPF

Section One - Notice To Patients of Potential Consequences of Refusing Recommended Health Care

You may have a medical condition that cannot be properly diagnosed and/or treated without the recommended examination/screening, test, treatment, procedure or medication If the medical condition is not diagnosed and/or treated, your health may deteriorate possibly resulting in irreparable harm or death

Section Two - Patient: check all boxes which apply and explain what health care is being refused.

☐ Refuse to permit a health provider to conduct a recommended medical examination/screening

☐ Refuse to permit a specimen be obtained Describe:

☒ Refuse to undergo a test/treatment/procedure. Describe: Foot soak, Application of minercin

☐ Refuse to take the prescribed medication(s) listed on the lines below

Section Three – Patient. describe your reason(s) for refusing recommended health care

Section Four: Statement and signature by patient.

- I am making the decision to refuse recommended health care voluntarily.
- I understand that I do not give up my rights to receive health care to which I consent.
- The known consequences of refusing the above recommended health care have been explained to me
- I understand that emergency care may be provided as necessary to sustain my life.

PATIENT SIGNATURE	DATE SIGNED
WITNESS SIGNATURE	DATE SIGNED
S. Edl, RN	3-17-17
WITNESS SIGNATURE	DATE SIGNED
Sgt Kolle	3-17-17

DISTRIBUTION: Original - Medical Chart, Consents/Refusals or Dental Record, Consents/Authorizations Section

EXHIBIT 1000 - 16

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3220 (Rev 5/2010)

WISCONSIN
Wisconsin Statute
Section 302 384

REFUSAL OF RECOMMENDED HEALTH CARE

PATIENT NAME (Last, First)	DOC NUMBER	FACILITY
Connor Eric	A20475	WSPF

Section One - Notice To Patients of Potential Consequences of Refusing Recommended Health Care.

You may have a medical condition that cannot be properly diagnosed and/or treated without the recommended examination/screening, test, treatment, procedure or medication If the medical condition is not diagnosed and/or treated, your health may deteriorate possibly resulting in irreparable harm or death

Section Two - Patient: check all boxes which apply and explain what health care is being refused

☐ Refuse to permit a health provider to conduct a recommended medical examination/screening.

☐ Refuse to permit a specimen be obtained. Describe.

☒ Refuse to undergo a test/treatment/procedure. Describe: foot care requested via HSR

☐ Refuse to take the prescribed medication(s) listed on the lines below

Section Three – Patient: describe your reason(s) for refusing recommended health care.

Section Four. Statement and signature by patient.

- I am making the decision to refuse recommended health care voluntarily
- I understand that I do not give up my rights to receive health care to which I consent.
- The known consequences of refusing the above recommended health care have been explained to me
- I understand that emergency care may be provided as necessary to sustain my life.

PATIENT SIGNATURE	DATE SIGNED
WITNESS SIGNATURE	DATE SIGNED
Gaeckler C/O	3-16-17
WITNESS SIGNATURE	DATE SIGNED
M. K RN	

DISTRIBUTION: Original - Medical Chart, Consents/Refusals or Dental Record, Consents/Authorizations Section

EXHIBIT 1000 - 17

PATIENT NAME Last	First	MI	DOC NUMBER
Conner	Eric		420475

DATE	TIME	PROGRESS NOTES – SUBJECT, OBJECTIVE, ASSESSMENT, PLAN
3/21/17	09.00	Pt. seen for daily foot care Feet soaked in Epsom salt, dried, and minerin cream applied ——— N. Bethel RN
3/22/17	1300	Pt. did not want foot care done today - ——— N. Bethel RN
3-23-17	0850	Pt. refused foot care tx, DOC 3220 signed by Sgt + nurse. ——— C. Edl, RN
3-22-17		Called unit to ask about conducting Mr Conners HSU file review. Mr Conner is still in obs, his review will not take place until he is out of obs. He then must resubmit a request for a file review. JK COA
3.24.17	0900	Pt. refused daily foot care, as reported by Sgt. Yanske as the pt. verbally refused via interview. DOC 3220 obtained. Pt. unable to sign d/t clinical observation status, therefore, Sgt. Yanske signed. RN to call front to check pt. ——— Anderson
3.25.17	1300	Pt. seen for foot care. Labs reviewed with Pt. Pt states he is suicidal because "John is trapped inside of me and the only way to set him free is to kill myself." Pt. feels like he is loosing weight. current weight is 198 lbs. Foot care done — N. Bethel RN
3.26.17	1800	Pt. refuses daily foot care. Unable to sign DOC 3220 — Signed by C.O. due to Pt. being in clinical observation. ~~Pt. verbalizes~~ error ——— Brame, RN

DISTRIBUTION Original – Medical Chart, Progress Notes Section

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3220 (Rev 5/2010)

WISCONSIN
Wisconsin Statute
Section 302 384

REFUSAL OF RECOMMENDED HEALTH CARE

PATIENT NAME (Last, First)	DOC NUMBER	FACILITY
Conner, Eric	420475	WSPF

Section One - Notice To Patients of Potential Consequences of Refusing Recommended Health Care.

You may have a medical condition that cannot be properly diagnosed and/or treated without the recommended examination/screening, test, treatment, procedure or medication. If the medical condition is not diagnosed and/or treated, your health may deteriorate possibly resulting in irreparable harm or death

Section Two - Patient. check all boxes which apply and explain what health care is being refused

☐ Refuse to permit a health provider to conduct a recommended medical examination/screening

☐ Refuse to permit a specimen be obtained. Describe: _____

☒ Refuse to undergo a test/treatment/procedure. Describe: Daily Foot Care per HSU

☐ Refuse to take the prescribed medication(s) listed on the lines below.

Section Three – Patient: describe your reason(s) for refusing recommended health care.

Section Four: Statement and signature by patient.

- I am making the decision to refuse recommended health care voluntarily.
- I understand that I do not give up my rights to receive health care to which I consent.
- The known consequences of refusing the above recommended health care have been explained to me
- I understand that emergency care may be provided as necessary to sustain my life.

PATIENT SIGNATURE	DATE SIGNED
Verbally refused - in Obs. no pens allowed	3-26-17
WITNESS SIGNATURE	DATE SIGNED
Sgt. Berges	3/26
WITNESS SIGNATURE	DATE SIGNED
B. Kramer, RN	3-26-17

DISTRIBUTION: Original - Medical Chart, Consents/Refusals or Dental Record, Consents/Authorizations Section

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3220 (Rev 5/2010)

WISCONSIN
Wisconsin Statute
Section 302 384

A401

REFUSAL OF RECOMMENDED HEALTH CARE

PATIENT NAME (Last, First)	DOC NUMBER	FACILITY
Conner, Eric	420425	WSPF

Section One - Notice To Patients of Potential Consequences of Refusing Recommended Health Care.

You may have a medical condition that cannot be properly diagnosed and/or treated without the recommended examination/screening, test, treatment, procedure or medication. If the medical condition is not diagnosed and/or treated, your health may deteriorate possibly resulting in irreparable harm or death.

Section Two - Patient: check all boxes which apply and explain what health care is being refused.

☒ Refuse to permit a health provider to conduct a recommended medical examination/screening. daily foot care

☐ Refuse to permit a specimen be obtained. Describe: _____

☐ Refuse to undergo a test/treatment/procedure. Describe: _____

☐ Refuse to take the prescribed medication(s) listed on the lines below.

Section Three – Patient: describe your reason(s) for refusing recommended health care.

Section Four: Statement and signature by patient.

- I am making the decision to refuse recommended health care voluntarily.
- I understand that I do not give up my rights to receive health care to which I consent.
- The known consequences of refusing the above recommended health care have been explained to me.
- I understand that emergency care may be provided as necessary to sustain my life.

PATIENT SIGNATURE	DATE SIGNED
X In Clinical observation - unable to sign	3.24.17
WITNESS SIGNATURE	DATE SIGNED
Sgt. Yanzy	3/24/17
WITNESS SIGNATURE	DATE SIGNED
J Anderson RN	3.24.17

DISTRIBUTION: Original - Medical Chart, Consents/Refusals or Dental Record, Consents/Authorizations Section

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3220 (Rev 5/2010)

WISCONSIN
Wisconsin Statute
Section 302 384

REFUSAL OF RECOMMENDED HEALTH CARE

PATIENT	DOC NUMBER	FACILITY
CONNER, Eric **DOC#:** 420475 DOB: [redacted]		WSPF

Section One - Notice To Patients of Potential Consequences of Refusing Recommended Health Care

You may have a medical condition that cannot be properly diagnosed and/or treated without the recommended examination/screening, test, treatment, procedure or medication. If the medical condition is not diagnosed and/or treated, your health may deteriorate possibly resulting in irreparable harm or death

Section Two - Patient. check all boxes which apply and explain what health care is being refused

☐ Refuse to permit a health provider to conduct a recommended medical examination/screening.

☐ Refuse to permit a specimen be obtained Describe: _____

☒ Refuse to undergo a test/treatment/procedure Describe. HSU foot care treatment

☐ Refuse to take the prescribed medication(s) listed on the lines below.

Section Three – Patient. describe your reason(s) for refusing recommended health care.

Section Four Statement and signature by patient.

- I am making the decision to refuse recommended health care voluntarily
- I understand that I do not give up my rights to receive health care to which I consent
- The known consequences of refusing the above recommended health care have been explained to me
- I understand that emergency care may be provided as necessary to sustain my life

PATIENT SIGNATURE	DATE SIGNED
WITNESS SIGNATURE	DATE SIGNED
Sgt. Yansh	3/23/17
WITNESS SIGNATURE	DATE SIGNED
J. Edl, RN	3-23-17

DISTRIBUTION: Original - Medical Chart, Consents/Refusals or Dental Record, Consents/Authorizations Section

EXHIBIT 1000 - 21

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev 9/2016)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Adm Code
Ch DOC 316

é NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY ⇦

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Conner	Eric	420475
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
WSPF	A 402	3/26/17

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT:

I understand the following

- The Department of Corrections shall charge a copayment of $7 50 for a visit (face to face contact) initiated by a patient when a copayment is required.
- I will not be denied care if I am unable to pay the copayment
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required

PATIENT SIGNATURE

▶ Officer Monday I/M in OBS

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment: ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE	DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided Place all 4 pages of the completed form in the sick call box The HSU will send a copy back to you indicating that your request has been received

☐ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)

☐ PSYCHIATRIST ☐ INFORMATION

☒ OTHER HSU Manager / Provider

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

I would like my skin ~~toathons~~ lotions I've been unable to shower because I'm unable to use my skin lotion after I get out of showering causing me to get dry skin Please allow me to receive my skin lotions.

DATE RECEIVED: TO BE STAMPED BY HSU

MAR 27 2017

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below. Add written comments / information as needed

☐ Nursing Sick Call ☐ Today ☐ Date (if not today).

☐ Scheduled to be seen in HSU ☐ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other

☐ Refer HSR to: ☐ ACP ☒ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other

☐ Refer for copies only. ☐ Refer for Health Care Record review appointment

☐ Educational material attached (Specify): ☐ Other.

COMMENT / INFORMATION

Mr Conner, You can not have any lotions or creams as you covers your camera. It is a PSU decision because you continue to threaten self harm and remain in clinical observation status The nurses can schedule lotion application at HSU

PRINT STAFF NAME	DATE OF HSU RESPONSE
J Utermark RN HSM	3/27/17

ORIGINAL - PATIENT REQUEST FOLDER

EXHIBIT 1000 - 22

PATIENT NAME Last	First	MI	DOC NUMBER
Conner	Eric		

DATE	TIME	PROGRESS NOTES – SUBJECT, OBJECTIVE, ASSESSMENT, PLAN
3/31/17	1530	Foot care completed noted during foot care patient to sit in wide stance while nurse was drying feet off note patient has only small on patient exposing himself patient instructed at this time to keep with his foot care patient argumentative but did comply —— [signature]
4-3-17	1738	Pt refused to come to HSU for foot care. DOC 3220 obtained. —— P.Edl RN
4/5/17	0800	Pt. refused lab work, rescheduled for next week —— N. Bethel RN
04/07/17	1400	30 y/o A-A male enters Alpha HSU c c/o generalized body aches. S: As above ② Pt. is concerned that the trays he receives in observation are markedly lower in calories than regular trays. O: 123/87 – 59 – 18 Wt: 195#. BMI: 30. A: ① Myalgia ② Nutritional concerns P: ① Recommended use of Ibuprofen or lidocaine cream OTC. ② Will check c dietary re: # calories in observation trays vs. regular trays. Current weight is about 11# less than in January. [signature]

DISTRIBUTION. Original – Medical Chart, Progress Notes Section

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3220 (Rev 5/2010)

WISCONSIN
Wisconsin Statute
Section 302 384

REFUSAL OF RECOMMENDED HEALTH CARE

PATIENT NAME (Last, First)	DOC NUMBER	FACILITY
Conner, Eric	420475	WSPF

Section One - Notice To Patients of Potential Consequences of Refusing Recommended Health Care.

You may have a medical condition that cannot be properly diagnosed and/or treated without the recommended examination/screening, test, treatment, procedure or medication. If the medical condition is not diagnosed and/or treated, your health may deteriorate possibly resulting in irreparable harm or death.

Section Two - Patient: check all boxes which apply and explain what health care is being refused.

☐ Refuse to permit a health provider to conduct a recommended medical examination/screening.

☐ Refuse to permit a specimen be obtained. Describe:

☒ Refuse to undergo a test/treatment/procedure. Describe: foot soak, lotion

☐ Refuse to take the prescribed medication(s) listed on the lines below.

Section Three – Patient: describe your reason(s) for refusing recommended health care

Section Four: Statement and signature by patient.

- I am making the decision to refuse recommended health care voluntarily.
- I understand that I do not give up my rights to receive health care to which I consent.
- The known consequences of refusing the above recommended health care have been explained to me.
- I understand that emergency care may be provided as necessary to sustain my life.

PATIENT SIGNATURE	DATE SIGNED
WITNESS SIGNATURE	DATE SIGNED
L.T. [signature]	4/3/17
WITNESS SIGNATURE	DATE SIGNED
L. Edl, RN	4-3-17

DISTRIBUTION: Original - Medical Chart, Consents/Refusals or Dental Record, Consents/Authorizations Section

DEPARTMENT OF CORRECTIONS
Division of Adult Institutions
DOC-3035 (Rev 9/2016)

HEALTH SERVICE REQUEST AND COPAYMENT DISBURSEMENT AUTHORIZATION

WISCONSIN
Adm Code
Ch DOC 316

NOTIFY ANY FACILITY STAFF IF YOUR HEALTH CARE NEED IS AN EMERGENCY

PRINT LAST NAME	PRINT FIRST NAME	DOC NUMBER
Conner	Eric	420475
FACILITY NAME	**HOUSING UNIT**	**TODAY'S DATE**
WSPF	Alpha OB's 402	4-6-17

COPAYMENT DISBURSEMENT REQUEST SECTION

AGREEMENT BY PATIENT

I understand the following

- The Department of Corrections shall charge a copayment of $7 50 for a visit (face to face contact) initiated by a patient when a copayment is required
- I will not be denied care if I am unable to pay the copayment
- By signing below, I am initiating a request for disbursement of my funds for the copayment at the time of the visit when a copayment is required
- Failure to sign below will NOT prevent the copayment from being withdrawn from my account following a visit when a copayment is required.

PATIENT SIGNATURE

▶ CO [signature] Inmate Conner in Observation

TO BE COMPLETED BY HSU ONLY

☐ MEDICAL (Nurse, Doctor/NP/PA) ☐ DENTAL ☐ OPTICAL

Charge Copayment ☐ Yes ☐ No

AUTHORIZED STAFF SIGNATURE	DATE OF SERVICE

TO BE COMPLETED BY INMATE PATIENT - HEALTH SERVICE REQUEST SECTION

Be sure to include today's date on top of form. Check the appropriate box below, and explain your request on the lines provided Place all 4 pages of the completed form in the sick call box The HSU will send a copy back to you indicating that your request has been received

☐ HEALTH SERVICES ☐ HEALTH CARE RECORD REVIEW ☐ COPIES FROM HEALTH CARE RECORD (List records below)
☐ PSYCHIATRIST ☐ INFORMATION
☑ OTHER: To HSU Manager and Provider

Please provide a brief description below of the services you desire so that HSU can respond to your request appropriately.

I was denied medical treatment for my skin between ~~4-3-17~~ 3-3-17 to 4-3-17. Between this time, I suffered dry and itchy skin and was unable to shower because I was denied medical skin lotion. I complain to you, the provider and various WSPF nurses without remedy.

DATE RECEIVED: TO BE STAMPED BY HSU

APR 7 2017

FOLD THE BOTTOM OF THE FORM UP TO THE DOTTED LINE SO THAT INFORMATION REMAINS CONFIDENTIAL.

PATIENT: DO NOT WRITE BELOW THIS LINE – TO BE COMPLETED BY HSU ONLY

HSU RESPONSE Check appropriate box below Add written comments / information as needed.

☐ Nursing Sick Call. ☐ Today ☐ Date (if not today):

☒ Scheduled to be seen in HSU ☒ ACP ☐ RN/LPN ☐ Special Needs Evaluation ☐ Optical ☐ Other.

☐ Refer HSR to: ☐ ACP ☐ HSU Manager ☐ Psychiatrist ☐ MPAA ☐ Optical ☐ Other.

☐ Refer for copies only ☐ Refer for Health Care Record review appointment

☐ Educational material attached (Specify) ☐ Other

COMMENT / INFORMATION

You are scheduled to see the ACP for this issue

PRINT STAFF NAME	DATE OF HSU RESPONSE
N. Bethel RN	4/7/17

ORIGINAL - PATIENT REQUEST FOLDER

EXHIBIT 1000 - 25